2004 Catastrophic Mental Health Report

Utah Insurance Department

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The *2004 Catastrophic Mental Health Report* was prepared pursuant to Utah Code Annotated (U.C.A.) § 31A-22-625(6)(b), by Jeffrey E. Hawley, Ph.D. of the Health Insurance Division for the Utah Insurance Commissioner.

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Executive Summary

The purpose of this report is to comply with the statutory requirements of Utah Code Annotated (U.C.A.) § 31A-22-625(6)(b), which requires the Utah Insurance Commissioner to report to the Health and Human Services Interim Committee the percentage of contracts and policies with mental health coverage as permitted under U.C.A. § 31A-22-625. The report also includes the results of the Utah Insurance Department's research study, which estimates the impact of the catastrophic mental health statute on the commercial health insurance market during 1999 to 2002. The study is based on information obtained from commercial health insurers, the Utah Department of Health, and the available research literature on mental health and mental health parity statutes. Using four years of data from approximately 90 percent of the commercial health insurance market (ranging from approximately 78 percent of the market in 1999 to 98 percent of the market in 2002), the Utah Insurance Department estimated the impact of the catastrophic mental health statute on commercial health insurance coverage, the commercially insured population with mental illness, and comprehensive claim costs in the commercial group health insurance market.

Coverage Impact. In 1999, prior to the passage of the catastrophic mental health statute, nearly 80 percent of commercially insured members had some type of mental health coverage. This percentage appears to have increased after the catastrophic mental health statute was in place. For example, by 2002, nearly 93 percent of commercially insured members had some type of mental health coverage, a 13 percent increase from 1999 to 2002.

This increase in coverage occurred in both the large and small group markets, with a slightly greater impact in the small group market. Generally, the data suggests that few employers terminated coverage during this period and some chose to increase coverage for the treatment of mental illness. Furthermore, mental health coverage also appears to have become more standardized during this period. For example, by 2002, most small group plans reported fifty/fifty coverage, whereas most large group plans reported catastrophic coverage. Few health insurers reported coverage that exceeded the minimum requirements of the catastrophic mental health statute.

Population Impact. The catastrophic mental health statute applies only to employer group plans in the commercial health insurance market. This market provides coverage for approximately 29 percent of Utah residents. Based on national prevalence estimates of mental illness, between 1.0 and 1.7 percent of Utah residents and their families are directly affected by the statute.

Financial Impact. Financial impact was measured using data from 1999 to 2002. All data was adjusted to 1999 dollars using the Medical Care Price Index and weighted by member years. During this four-year period, average comprehensive losses per member per year increased by 11.8 percent, whereas mental health losses per member per year increased by approximately 87.0 percent.

To put this cost increase in perspective, the cost of mental health services as a percentage of comprehensive losses per member per year increased from 1.3 percent in 1999 to 2.2 percent

in 2002, a relative increase of 0.9 percent. Thus, mental health services, as measured in this study, did not exceed 2.2 percent of comprehensive losses per member per year during the four years data was available and does not appear to have increased comprehensive claim costs more than 1.0 percent. The Utah Insurance Department's cost estimate is consistent with the Legislative Fiscal Analyst's previous estimate that the premium impact of the catastrophic mental health statute would range between a 2.0 percent savings and a 7.0 percent increase. It is also consistent with other national and state cost estimates of mental health parity legislation.

Estimated Benefits. Reviews of mental health treatment, such as the Surgeon General's report on mental health, suggest that mental health treatment can be effective in reducing the symptoms of mental illness, which in turn may reduce health care costs, increase productivity, and improve the quality of life for those with mental illness and their families. Although the available data did not permit the Utah Insurance Department to test these factors directly, the data did suggest three trends that may be beneficial to commercially insured members with mental illness. First, there was a moderate increase in the number of commercially insured members with insurance coverage for the treatment of mental illness. Second, there was a significant decline in the number of inpatient days per member per year and an increase in the number of outpatient visits per member per year, which suggests a shift from inpatient to outpatient services. Third, commercial health insurers covered a larger percentage of the cost of mental health services in 2002 than in 1999. While this provided a financial benefit to members who utilized mental health services, it also increased the average cost per claim for mental health services among commercial health insurers.

Introduction

In 1996, the federal government enacted the Mental Health Parity Act. Effective January 1, 1998, this law required employer group health plans that offer mental health coverage to provide the same lifetime and annual payment limits for the coverage of mental health services as for the coverage of general medical services. The law applies equally to both employer self-funded and commercially insured group health plans. The Mental Health Parity Act does not affect service limits or cost sharing arrangements, nor does it mandate mental health coverage or prevent employer group health plans from dropping mental health coverage. The law was originally scheduled to expire September 30, 2001 (Mental Health Parity Act of 1996, 1999), but has been reauthorized until December 31, 2004 (Mental Health Parity Reauthorization Act of 2003, 2003). Since it's passage, this federal law has stimulated significant legislative activity among the states.

Prior to 1996, only five states had passed some type of mental health parity legislation, however after the federal Mental Health Parity Act was enacted, twenty-six additional states passed some type of mental health parity legislation (National Institutes of Mental Health, 2000). By 2002, thirty states, including Utah, had a mental health parity statute (GAO, 2003) and by 2004, forty-six states had some form of mental health parity in force (Rickert & Ro, 2003; National Conference of State Legislatures, 2004). Although most states have a mental health parity statute, there is a wide variety in what "parity" means and what each statute requires. Statutes range from simply adopting the federal Mental Health Parity Act standards as state law to full mental health parity. Among the states that had a mental health parity law in 2004, most involved some form of mandated benefit (see Table 1).

Table 1. Number of States With Mental Health Parity Statutes

	Count
States with "Mandated Benefit" statute [a]	27
States with "Mandated Benefit Offering" statute [b]	12
States with "Mandated, If Offered" statute [c]	7
Total number of states with a mental health parity statute	**46**

Data Source: Adapted from the National Conference of State Legislatures (2004).
[a] "Mandated Benefit" requires insurers to include mental health coverage in all health insurance policies they sell.
[b] "Mandated Benefit Offering" requires sellers to offer mental health coverage, but the decision to purchase coverage is left to the buyer.
[c] "Mandated, If Offered" does not mandate mental health coverage or require insurers to offer mental health coverage. However, if coverage is offered, then the coverage must comply with the parity provisions in state law.

Utah's mental health statute was created during the 2000 Legislative session when the Utah Legislature passed H.B. 35 "Catastrophic Mental Health Insurance Coverage". This bill enacted Utah Code Annotated (U.C.A.) § 31A-22-625 "Catastrophic coverage of mental health conditions" (see "U.C.A. § 31A-22-625" in the Appendix). Under this law, commercial health insurers must offer mental health coverage to employers at the time of purchase and renewal (a "mandated benefit offering" statute, whereas, the federal Mental Health Parity Act of 1996 is a "mandated, if offered" statute). Utah's law applies only to commercially insured group health

plans sold to employers. It does not affect employer self-funded group health plans. The federal mental health parity law also applies in conjunction with Utah's mental health parity statute.

Mental Health Coverage Under U.C.A. § 31A-22-625

Under Utah's mental health parity statute, employers have the option to accept or reject mental health coverage as part of purchasing a group health insurance policy. For large employers (employers with 51 or more employees), commercial health insurers must offer a group health insurance policy with no mental coverage, catastrophic mental health coverage, or mental health coverage that exceeds the minimum requirements of U.C.A. § 31A-22-625. For small employers (employers with between 2 and 50 employees), commercial health insurers must offer a health insurance package with no mental health coverage, fifty/fifty mental health coverage, catastrophic mental health coverage, or mental health coverage that exceeds the minimum requirements of U.C.A. § 31A-22-625.

Under the various options, the statute primarily impacts the benefit level limits that commercial health insurers can offer in an employer group policy. The statute does not mandate mental health coverage for employers and does not affect cost sharing arrangements, such as deductibles and coinsurance (except on a limited basis under small group plans with fifty/fifty coverage). Below is a brief description of each of the four coverage options.

"No mental health coverage" means health insurance coverage without coverage for the diagnosis and treatment of mental health conditions. This category applies to both small and large group comprehensive policies.

"Catastrophic mental health coverage" means coverage that does not impose any lifetime, annual, episodic, inpatient service, outpatient service, or maximum out of pocket limit that places a greater financial burden on an insured member for the evaluation and treatment of a mental health condition than for a physical health condition (see also U.C.A. § 31A-22-625(1)(a)). "Mental health condition" means any condition or disorder involving mental illness that falls under any of the diagnostic categories listed in the Diagnostic and Statistical Manual, as periodically revised (see also U.C.A. § 31A-22-625(1)(d)). This category applies to both small and large group comprehensive policies.

"Fifty/fifty mental health coverage" means coverage that pays for at least 50 percent of covered services for the diagnosis and treatment of mental health conditions (see also U.C.A. § 31A-22-625(1)(b)). "Mental health condition" means any condition or disorder involving mental illness that falls under any of the diagnostic categories listed in the Diagnostic and Statistical Manual, as periodically revised (see also U.C.A. § 31A-22-625(1)(d)). This category only applies to small group comprehensive policies.

"Coverage that exceeds minimum requirements" means U.C.A. § 31A-22-625 allows insurers to offer coverage that exceeds the minimum requirements required under catastrophic and fifty/fifty mental health coverage. This category applies to both small and large group comprehensive policies.

The Office of the Legislative Fiscal Analyst estimated that the statute could have a wide range of impact on premiums. Depending on how employers and health insurers respond to the statute, the law could cause premiums to change anywhere from a 2.0 percent savings to a 7.0 percent increase (see "Fiscal Note for H.B. 35" in the Appendix). The statute is scheduled to expire July 1, 2011. The statute also requires the Insurance Commissioner to adopt rules as necessary to ensure compliance with U.C.A. § 31A-22-625 and to provide general figures on the percentage of contracts and policies that include no mental health coverage, fifty/fifty mental health coverage, catastrophic mental health coverage, and coverage that exceeds the minimum requirements of the statute.

The purpose of this report is to comply with the requirements of U.C.A. § 31A 22-625. In addition to providing general figures on the distribution of mental coverage, the report includes a research study that estimates the impact of U.C.A. § 31A-22-625 on the commercial health insurance market.

Defining Mental Health and Mental Illness

Making universal distinctions between mental and physical health has proven to be a difficult task. This is, in part, because mental health and mental illness are not absolute opposites, but exist on a continuum. Furthermore, mental illness and physical illness are often related. For example, many mental illnesses have a biological cause, accompany a physical health condition, or exist as complications of other physical diseases. Mental illness can also to be a risk factor for physical illnesses and visa versa. In addition, how mental health or mental illness is defined by society is influenced by value judgments as well as other social and cultural factors.

The Office of the Surgeon General defines *mental health* as "…the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity" (U. S. Department of Health and Human Services, 1999, p. 5). In contrast, *mental illness* is "…the term that refers collectively to all mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning." (U. S. Department of Health and Human Services, 1999, p. 6). These alterations in thinking, mood, or behavior may cause multiple problems, including patient distress, impaired functioning, or heightened risk of death, pain, disability, or loss of freedom (American Psychiatric Association, 2000).

The primary clinical standard for the diagnosis of mental disorders in the United States is the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (DSM-IV). Most mental disorders can be classified into a least one of four symptom areas: anxiety disorders, mood disorders, cognitive impairments, and psychosis (disturbances of thought and perception) (U. S. Department of Health and Human Services, 1999).

Current prevalence estimates suggest that as many as 20 percent (one in five) of Americans suffer from a diagnosable mental disorder in any given year (U. S. Department of Health and Human Services, 1999), but only 9 percent (about half of those with a mental disorder) report impairment in daily functioning due to the mental disorder (National Advisory Mental Health Council, 1993).

Federal regulations define serious mental disorders differently for adults and children. For adults, the term "serious mental illness" is used and refers to mental disorders that interfere with an area of social functioning. For children, the term "serious emotional disturbance" is used and refers to mental disorders with a severe functional limitation (U. S. Department of Health and Human Services, 1999).

The most serious and disabling conditions affect approximately 5.4 percent of adults (those with serious mental illness (SMI)) and between 5 and 7 percent of children ages 9 to 17 (those with serious emotional disturbance (SED)) (Regier, Narrow, Rae, Manderscheid, Locke, & Goodwin, 1993; Children With Serious Emotional Disturbance, 1998; Utah State Division of Substance Abuse and Mental Health, 2003).

Use of Mental Health Services

Approximately 15 percent of adults and approximately 21 percent of children in the United States receive services from the mental health service system each year (see Table 2). The mental health service system in the United States can be divided into four sectors: specialty mental health, general medical, human services, and voluntary support networks (see U. S. Department of Health and Human Services, 1999).

Table 2. Proportion of Population Using Mental Health Services in One Year

	Adults (Ages 18 and older)	Children (Ages 9 to 17)
Total Health Sector	11%*	9%*
Specialty Mental Health	6%	8%
General Medical	6%	3%
Human Services Professionals	5%	17%*
School Services	-	16%
Other Human Services	-	3%
Voluntary Support Network	3%	-
Any of Above Services	**15%***	**21%***

Source: Adapted from U. S. Health and Human Services (1999).
Note: Data represents results from multiple surveys.
* Subtotals do not add up due to overlap.

The *specialty mental health* sector includes mental health professionals specifically trained to treat mental disorders such as psychiatrists, psychologists, psychiatric nurses, psychiatric social workers, etc. Services are provided via outpatient office settings, clinics, and psychiatric hospitals in both the public and private sectors. This sector serves about 6 percent of adults and about 8 percent of children.

The *general medical* sector includes general health care professionals such as primary care physicians, nurse practitioners, nurses, etc. Services are provided in office based practice, clinics, and hospitals in both the public and private sectors. The general medical sector is often the first point of contact for mental health services and serves about 6 percent of adults and about 3 percent of children.

The *human services* sector includes social services, school-based counseling services, residential rehabilitation services, vocational rehabilitation, criminal justice/prison-based services, and religious professional counselors. For children, the human services sector is a major source of care, serving approximately 17 percent of children.

The *voluntary support network* sector consists of self-help groups and other voluntary services. This sector is a rapidly growing component of the mental health service system. This sector currently services only about 3 percent of the adult population.

As shown in Table 2, most of the treatment for mental disorders is provided in the health sector either by specialty mental health or general medical professionals. One exception is children, who receive a significant amount of their services from public schools. Generally, health insurance does not cover mental health services from every part of the mental health service system. For example, public and private health insurance usually only cover mental services provided in the health sector, with services provided by the general medical sector paid for under standard major medical coverage and services provided by the specialty mental health sector paid for under mental health coverage. In contrast, mental health services provided by the human services sector and in the voluntary support network are typically not covered by health insurance.

Cost of Mental Illness

Indirect Costs. In 1990, the indirect cost of mental illness on the U.S. economy was estimated to be approximately $79 billion (see U.S. Health and Human Services, 1999). Approximately 80 percent of that amount ($63 billion) reflects morbidity costs—the loss of productivity in usual activities because of illness. But these indirect costs also include nearly $12 billion in mortality costs (lost productivity due to premature death), and almost $4 billion in productivity losses for incarcerated individuals and for the time spent by individuals providing family care. The World Health Organization estimates that mental disorders account for approximately 15 percent of the burden of disease from all causes (Murray & Lopez, 1996) and is the leading source of disability in the United States, Canada, and Europe (World Health Organization, 2001).

Direct Costs. According to the Substance Abuse and Mental Health Services Administration, the total health care spending in the United States for all health conditions in 1996 was nearly $943 billion, with approximately $69 billion spent for mental health services (U.S. Health and Human Services, 1999). This puts the direct cost mental illness in the U.S. at about seven percent of all health care spending (see Table 3).

Table 3. Mental Health Expenditures in Relation to National Health Expenditures

	Expenditures in Billions (1996)		
	Mental Health Care	**All Health Care**	**Percentage**
Private			
Client Out-of-Pocket	$11	$171	6%
Private Insurance	$17	$292	6%
Other Private	$2	$32	5%
Total Private	$30	$495	6%
Public			
Medicare	$10	$198	5%
Medicaid	$13	$140	9%
Other Federal Government	$1	$41	3%
State/Local Government	$12	$69	18%
Total Public	$36	$447	8%
Total Expenditures	**$66**	**$943**	**7%**

Source: Adapted from U. S. Health and Human Services (1999, p. 416).
Note: Some specialty providers who work for social services industries were excluded from national health spending estimates. As a result, estimates of mental health care spending had to be reduced from $69 billion to $66 billion in order to make direct comparisons with total health care spending.

Nearly all of the spending for mental health services is in the health sector. More than 70 percent of the cost is for specialty mental health, with nearly 20 percent for general medical, and about 9 percent for prescription drugs (U.S. Health and Human Services, 1999). According to the Surgeon General, nearly two-thirds of psychotropic prescription drugs are prescribed by medical doctors in the general medical sector and only one-third are prescribed by psychiatrists in the specialty mental health sector (Pincus, Tanielian, Marcus, Olfson, Thompson, & Magno Zito, 1998; U.S. Department of Health and Human Services, 1999). Overall, this data suggests that roughly 5 percent of health care spending is for specialty mental health services, one percent is for mental health care in the general medical sector, and less than one percent is for psychotropic drugs (see Table 4). This is an important distinction, as most cost estimates for mental health parity focus on the cost of providing services from the specialty mental health sector (see Review of Previous Cost Estimates).

Table 4. Total Mental Health Expenditures by Provider Type, 1996 Health Accounts

	Percent of Total Mental Health Spending	Percent of Total Health Spending
Specialty Mental Health		
Psychiatric Hospitals	17%	
Psychiatrists	10%	
Psychologists/Social Workers	14%	
Multi-service mental health organizations	18%	
Residential treatment centers for children	4%	
General Medical Hospital Psychiatry Units	10%	
Total Specialty Mental Health	73%	5.1%
General Medical		
General Medical Physicians	5%	
General Medical Hospitals	6%	
Nursing Homes and Home health agencies	7%	
Total General Medical	18%	1.3%
Prescription Drugs (Psychotropic)*		
Total Prescription Drugs	9%	0.6%
Total	**100%**	**7.00%**

Data Source: Based on data presented in U.S. Health and Human Services (1999, p. 414).
Note: This table represents all health care spending for mental health services in the health sector. It does not include spending for human services professionals or the voluntary support network, as public or private health insurance programs do not usually pay for these services. For a more complete treatment of the subject see U.S. Health and Human Services (1999).
* Psychiatrists in the specialty mental health sector prescribe only one-third of psychotropic drugs, with the remainder being prescribed by physicians in the general medical sector (Pincus, Tanielian, Marcus, Olfson, Thompson, & Magno Zito, 1998; U.S. Department of Health and Human Services, 1999)

Mental Illness in Utah

At the time this study was conducted, few surveys of mental illness among Utah residents were available. This is due in part to the cost and methodological challenges of measuring mental illness. One important exception is the annual review of the public mental health system by the Utah State Division of Substance Abuse and Mental Health. While this survey provides an excellent review of the public mental health system, it does not include data from those receiving mental health services in the private sector. As a result, this survey may not represent the prevalence of mental illness in the state as a whole. As a result, the Utah State Division of Substance Abuse and Mental Health has adopted prevalence estimates of serious mental illness (SMI) for adults (age 18 and older) and serious emotional disturbance (SED) for children (ages 9 to 17) for Utah from two large-scale studies conducted by the National Institute of Mental Health and the U.S. Center for Mental Health Services (Geertsen, Colton, Justice, & Taylor, 2003; Utah State Division of Substance Abuse and Mental Health, 2003). These two studies serve as the national prevalence estimates for serious mental illness in the United States (U.S. Department of Health and Human Services, 1999) and are used by the Centers for Medicaid and Medicare Services (CMS) to create state based estimates of mental illness.

Based on these studies, the prevalence of serious mental illness for adults and serious emotional disturbance for children in Utah has been estimated to be approximately 5.4 percent for adults and between 5 and 7 percent for children (see Table 5). These are conservative estimates, given the fact that up to 20 percent of Americans may experience some form of mental illness in any one year.

However, these estimates are perhaps a good indicator of mental health spending, as those with serious mental illness are more likely to use specialty mental health services, which are the type of mental health service most likely to be paid for as "mental health services" under commercial health insurance coverage. As mentioned previously, commercial health insurers typically do not provide coverage for services from human services or assistance from volunteer/self-help sources, while mental health services provided by general medical professionals are typically covered under major medical overage.

Furthermore, these estimates of serious mental illness are also consistent with national estimates of mental health service use, with approximately 6 percent of adults and 8 percent of children using specialty mental health services in any one year (see Table 2). Based on these data sources and assumptions, it is possible to provide a rough estimate of Utah's need for mental health services (see Table 5).

Table 5. Estimated Number of Persons with Serious Mental Illness in Utah for 2002

	Resident Population	Lower Limit	Median	Upper Limit
Adults with Serious Mental Illness (18 and older)	1,603,244	59,320	86,575	113,830
As percent of Resident Population	**100%**	**3.7%**	**5.4%**	**7.1%**
Children with Serious Emotional Disturbance (9 to 17)	340,566	17,028	20,434	23,840
As percent of Resident Population	**100%**	**5.0%**	**6.0%**	**7.0%**
Remaining Child Population (0 to 8)	394,951	NA	NA	NA
As percent of Resident Population	**100%**	-	-	-
Estimated Population with Serious Mental Illness	2,338,761	76,348	107,009	137,670
As percent of Resident Population	**100%**	**3.3%**	**4.6%**	**5.9%**

Data Sources: Estimates for "Adults with Serious Mental Illness" and "Children with Serious Emotional Disturbance" were adapted from unpublished data obtained from the Utah State Division of Substance Abuse and Mental Health and are based on Federal estimates applied to Utah (see U. S. Department of Human Services (1999) and Children With Serious Emotional Disturbance (1998)). The estimate for the "Population with Serious Mental Illness" was created by the author and does not include any data for children under age 9 as such estimates are not currently available (see Children With Serious Emotional Disturbance (1998)). The prevalence estimate presented here must be considered to be a "best estimate" based on the available data. The actual prevalence of serious mental illness in Utah may be higher or lower than presented here.

Methodology

In compliance with U.C.A. § 31A-22-625, the Utah Insurance Department conducted a study of the catastrophic mental health statute. The study attempted to determine, to the extent possible, the statute's impact on commercial health insurance coverage, the commercially insured population with mental illness, and the cost of commercial health insurance.

Sampling

State insurance regulation affects only commercial insurance companies. Government sponsored and employer sponsored employee benefit plans are exempt (Utah Insurance Department, 2003). As a result, U.C.A. § 31A-22-625 applies only to commercial health insurance companies who offer group comprehensive health insurance coverage to small and large employers in Utah. Utah's group comprehensive health insurance market covers approximately one-third of Utah residents (see Table 6).

Table 6. Group Comprehensive Health Insurance Membership from 1999 to 2002

	1999	2000	2001	2002
Small Group	200,377	208,561	208,100	237,050
As percent of population	**9.37%**	**9.28%**	**9.06%**	**10.14%**
Large Group	655,112	624,524	534,484	447,623
As percent of population	**30.63%**	**27.80%**	**23.28%**	**19.14%**
Total Group	855,489	833,085	742,584	684,673
As percent of population	**39.99%**	**37.08%**	**32.34%**	**29.28%**
Utah Population	2,139,014	2,246,544	2,295,971	2,338,761
As percent of population	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Data Sources: Utah Accident & Health Survey and Utah Population Estimates Committee
Note: "As percent of population" measures the relative percentage of Utah's total population in each particular year.

Fifty-three commercial health insurance companies were selected for participation in this study. These companies represent more than 99 percent of Utah's group comprehensive health insurance market in 2002. These particular companies were selected for three main reasons. First, a wide sampling of the market was needed to estimate the effects of the statute on the market, particularly among small carriers and small employers. Second, some commercial health insurers are exempt under provisions in U.C.A. § 31A-1-301, which permit non-situated employer group policies with less than 25 percent of their insured members in Utah to be exempt from state mandates. These policies could not be identified without conducting a survey of current health insurers. Third, there is a very diverse approach to mental health coverage in Utah and the Utah Insurance Department wanted to ensure that the sample captured this variation.

Of the 53 health insurers surveyed, twenty-six of the largest health insurers (representing more than 90 percent of the group market (see Table 7)) reported mental health data that could be used in our analysis. Of the 27 remaining (representing less than 10 percent of the market), nine were excluded from analysis because the available data was not complete enough for a full analysis and 18 qualified for exemption under the provisions in U.C.A. § 31A-1-301. The insurers that were excluded from further analysis were typically insurers with a very small market share in Utah.

Table 7. Sampling of the Group Comprehensive Health Insurance Market from 1999 to 2002

	Sampled Insurers			Group Comprehensive Market	
	Company Count	Earned Premium	Market Share	Earned Premium	Market Share
1999	20	$806,549,876	78%	$1,030,148,638	100%
2000	24	$1,022,327,739	92%	$1,109,979,150	100%
2001	26	$1,135,852,119	97%	$1,167,412,975	100%
2002	26	$1,186,286,851	98%	$1,195,462,571	100%

Data Source: Utah Accident & Health Survey
Note: Market share calculations are based on total direct earned premium for group business as reported on the Utah Accident & Health Survey.

Data Collection and Analysis

Each health insurer was asked to provide data for the calendar years 1999, 2000, 2001, and 2002. For each year of data, each insurer was asked to provide information on membership, cost and utilization of mental health services, pharmacy, and total health care claims.

Unfortunately, a number of health insurers experienced difficulties in reporting complete mental health data. This was usually because of some kind of technical problem related to identifying and linking mental health claims to members with mental health coverage or problems dividing claims by the type of mental health coverage listed in U.C.A. § 31A-22-625. Those who could not provide complete data were excluded from further study. Fortunately, most large insurers were able to respond with detailed information. However, a few of the large insurers also experienced some difficulties isolating claims. In the case of one large insurer, their data systems were not able to link claims to the type of mental health coverage and in some cases were not able to capture all of the health care claims. This may have resulted in the underreporting of total health care claims in some cases. While this suggests that some additional caution should be used in interpreting the results, any error introduced by these problems is probably small.

Measuring Mental Health Services. Each health insurer was asked to provide information on inpatient and outpatient care for mental health services. Inpatient care included all claims billed for mental health services at any acute care hospital/facility as part of an inpatient stay. This included physician services, counseling, chemical dependency, and other forms of mental health treatments covered under the member's mental health benefit. Utilization was measured using the number of days stayed at the facility (not admissions) as defined by the number of dates of service. Outpatient care included all claims billed for mental health services performed in any outpatient setting. This included physician services, counseling, chemical

dependency, and other forms of mental health treatments covered under the insured member's mental health benefit. Utilization was measured by counting the number of unique dates of service. Cost was measured in two ways: total dollars paid by the insurer and total dollars paid by members. Similar measures of utilization and cost were also used for pharmacy and total health claims.

Coverage Impact. Utah law requires the Utah Insurance Department to report the percentage of insured members in each of the four categories described in U.C.A. § 31A-22-625. Coverage changes were measured using a classification system based on the categories listed in statute and membership data from 1999 to 2002.

Population Impact. Population impact was measured using national prevalence estimates applied to Utah and the commercial health insurance market. Measuring the rate of change in mental illness during the measurement period was not possible using this method.

Financial Impact. Financial impact was measured using two related instruments. First, insurers were asked to identify the members and claims under each mental health category. This data was organized by membership, mental health utilization and cost for inpatient and outpatient mental health services, pharmacy, and total comprehensive costs. The claim extract also included detailed information on the type of mental health services used as well as the amount paid by the insurer and the insured. Individual medical chart and cost data were not available. Premium data were obtained from the Utah Accident & Health Survey. All financial data was converted to 1999 dollars using the Medical Cost Price Index and weighted by member years. These data sources were used to estimate the impact of the mandate on the cost of health insurance in Utah's comprehensive health insurance market.

Results

The study is divided into five areas: coverage impact, population impact, financial impact, review of preview cost estimates, and estimated benefits. Each section is discussed separately.

Coverage Impact

The catastrophic mental health mandate went into effect January 1, 2001 for HMO plans and July 30, 2001 for all other group plans. Commercial health insurers reported four years of coverage data, two prior to the mandate and two after. According to this data, most comprehensive health insurers were providing some type of mental health coverage prior to the passage of the mandate. For example, approximately 80 percent of commercially insured members had some type of mental health coverage for both inpatient and outpatient mental health services prior to the passage of U.C.A. § 31A-22-625.

However, this coverage typically had limits on the number of days and visits, and in some cases, limits on the total amount of mental health services that a health insurer would cover that were different from general medical services. U.C.A. § 31A-22-625 places restrictions on the kinds of limits health insurers can implement in a group health insurance policy, but does not

directly affect cost sharing arrangements. Thus, the main impact of the statute appears to be raising the limits on the total dollar amount a health insurer might pay, but does not directly impact coinsurance, copayments, or deductibles. Furthermore, health insurers are required to offer mental health coverage under employer group health plans, but it is not a mandated benefit.

Under this arrangement, employers are free to accept or reject mental health coverage and health insurers are free to charge a reasonable premium for this coverage. Thus, employers might react to these circumstances in several ways: reduce existing coverage, maintain coverage, or increase coverage. The available data suggests that few employers reduced or eliminated existing coverage, and some increased coverage. For example, by 2002, the percentage of commercially insured members with mental health coverage had increased to 93 percent, a relative change of 13 percent (see Table 8). This is consistent with employer behavior nationally. According to the Kaiser/HRET Employer Health Benefits Survey, most employers (more than 90 percent) were offering coverage for mental health benefits during this same period (e.g., Kaiser/HRET, 2002).

Table 8. Changes in Mental Health Coverage in the Group Market from 1999 to 2002

	1999	2000	2001	2002	Percent Change in Coverage Distribution
No Mental Health Coverage	135,980	61,313	38,076	43,412	
As percent of Sample Total	**19.7%**	**8.6%**	**5.4%**	**6.7%**	**-13.0%**
Mental Health Coverage With Limits Allowed Prior to 31A-22-625 *	500,905	511,630	1,563	864	
As percent of Sample Total	**72.7%**	**71.9%**	**0.2%**	**0.1%**	**-72.6%**
Fifty/Fifty Mental Health Coverage (Small Employer Only)	16,019	51,627	204,591	205,979	
As percent of Sample Total	**2.3%**	**7.3%**	**29.2%**	**32.0%**	**29.7%**
Catastrophic Mental Health Coverage	21,239	76,044	434,190	373,195	
As percent of Sample Total	**3.1%**	**10.7%**	**61.9%**	**58.0%**	**54.9%**
Mental Health Coverage That Exceeds Minimum Requirements of 31A-22-625	13,509	10,381	21,748	18,256	
As percent of Sample Total	**2.0%**	**1.5%**	**3.1%**	**2.8%**	**0.9%**
Other Mental Health Coverage	934	1,030	1,371	1,472	
As percent of Sample Total	**0.1%**	**0.1%**	**0.2%**	**0.2%**	**0.1%**
Sample Total	688,586	712,025	701,539	643,178	
As percent of Sample Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**

Data Source: Utah Catastrophic Mental Health Survey.
Note: Membership is as of December 31 of each measurement year. Percentages are based on the total sample population for each measurement year.
* Prior to the passage of U.C.A. § 31A-22-625, most health insurers were providing coverage for both inpatient and outpatient mental health services. However, it was not practical to divide the data into numerous sub-categories. So for simplicity, coverage that existed prior to the passage of U.C.A. § 31A-22-625 that did not fit into one of the four classifications required by the mental health statute was placed in this category.

In addition to an increase in the number of members with coverage for the treatment of mental illness, the type of mental health coverage became more standardized. Specifically, by year-end 2002, most small group plans were reporting fifty/fifty coverage and most large group plans were reporting catastrophic coverage. Overall, the data suggests that employers purchased mental health coverage at a higher rate in 2002 than in 1999 and that small employers preferred the fifty/fifty option to the catastrophic option. Few health insurers reported coverage that exceeded the minimum requirements (see Table 8).

Population Impact

The catastrophic mental health statute only affects Utah's commercial health insurance market, specifically, those covered by employer group policies. Utah's group comprehensive health insurance market covers approximately 29 percent of Utah residents (see Table 3). Generally, the vast majority of members among comprehensive health insurers are between the ages of 0 to 64. Medicare usually covers those 65 and older. Assuming that the distribution of mental illness is the same as estimated for Utah from national prevalence surveys, the percentage of Utah residents with mental illness in the group comprehensive market would be between 1.0 percent and 1.7 percent (see Table 9). More precise estimates were not possible from the available data.

Table 9. Estimated Number of Persons with Serious Mental Illness in the Group Market

	Resident Population	Lower Limit	Median	Upper Limit
Group Market	684,673	22,300	31,300	40,300
As percent of Utah Population	**29%**	**1.0%**	**1.3%**	**1.7%**
Utah Population	2,338,761	76,348	107,009	137,670
As percent of Utah Population	**100%**	**3.3%**	**4.6%**	**5.9%**

Source: Utah Population Estimates Committee, Utah Accident & Health Survey, Data from Table 2
Note: These estimates are based on national prevalence estimates applied to Utah and the commercial group health insurance market. All data represents estimates for the year 2002 only. The actual prevalence of mental illness in the group market may be different than presented here.

Financial Impact

To measure financial impact, the cost of mental health services was measured as a percent of total comprehensive claims for the years 1999, 2000, 2001, and 2002. Data for 1999 and 2000 was assumed to be representative of conditions prior to the mandate, whereas data for 2001 and 2002 was assumed to be representative of conditions after the mandate. To minimize the effects of medical inflation and membership changes, all data was converted to 1999 dollars using the Medical Cost Price Index and weighted by member years. While every effort was made to control for extraneous effects, the study is correlational rather than causal in its design and other market forces besides the mandate must be assumed to affect the results.

Mental health services as percent of total comprehensive claims. During the period from 1999 to 2002, the comprehensive health insurance market experienced a significant increase in the cost of health insurance (Utah Insurance Department, 2003). Among the sampled health

insurers, comprehensive premium per member per year for group business increased by 18.9 percent. Comprehensive losses per member year (the portion of the claim paid by the insurer) increased by 11.8 percent, whereas, comprehensive out of pocket costs per member per year (the portion of the claim paid by the member) increased by 38.7 percent. Overall, the total cost per member per year (the insurer's portion and the member's portion combined) increased by 15.9 percent and the percentage of claims paid by the insurer declined slightly by 3 percent (see Table 10).

Table 10. Cost of Mental Health Services Under Group Health Insurance from 1999 to 2002

	1999	2000	2001	2002	Percent Change
Comprehensive Premium [a]					
Group Premium PMPY	$1,241.28	$1,303.31	$1,393.92	$1,475.38	18.9%
Estimated Employee Portion PMPY	$335.15	$351.89	$376.36	$398.35	-
Comprehensive Claims					
Losses PMPY (Paid By Insurer) [b]	$1,127.12	$1,083.93	$1,260.31	$1,260.09	11.8%
Out Of Pocket Cost PMPY (Paid By Member) [c]	$203.23	$210.41	$255.35	$281.90	38.7%
Total Cost PMPY (Losses plus Out Of Pocket)	$1,330.35	$1,294.33	$1,515.66	$1,541.99	15.9%
Percent of Total Cost PMPY Covered By Insurance	85%	84%	83%	82%	-3%
All Mental Health Services [d]					
Losses PMPY (Paid By Insurer)	$15.08	$18.08	$27.67	$28.20	87.0%
Out Of Pocket Cost PMPY (Paid By Member)	$6.37	$7.21	$8.90	$8.98	41.0%
Total Cost PMPY (Losses plus Out Of Pocket)	$21.45	$25.29	$36.57	$37.18	73.4%
Percent of Total Cost PMPY Covered By Insurance	70%	72%	76%	76%	6%
All Mental Health Services (as Percent of Total Claims)					
Losses PMPY (Paid By Insurer)	1.3%	1.7%	2.2%	2.2%	0.9%
Out Of Pocket Cost PMPY (Paid By Member)	3.1%	3.4%	3.5%	3.2%	0.1%
Total Cost PMPY (Losses plus Out Of Pocket)	1.6%	2.0%	2.4%	2.4%	0.8%

Data Sources: Utah Catastrophic Mental Health Survey and Utah Accident & Health Survey
Note: All data is adjusted for medical inflation to 1999 dollars using the Medical Cost Price Index. PMPY means per member per year.
[a] Group Premium PMPY was estimated using data from the Utah Accident & Health Survey. The employee's premium contribution was estimated using data from the Kaiser Employer Health Benefits Survey (Kaiser/HRET, 2002).
[b] Losses PMPY include payments made by health insurers for mental health services under capitation agreements.
[c] Out Of Pocket Cost PMPY does not include payments made by members for mental health services under capitation agreements. As a result, the data may underestimate slightly the true out of pocket costs for mental health services.
[d] All Mental Health Services does not include pharmacy costs. Most health insurers were unable to isolate prescriptions written only by mental health providers.

The increases in out of pocket costs (the portion of the claim paid by the member) may appear higher than they actually are. There was a slight increase in the percentage of claim costs paid by members, but this was small in relation to the overall trend and does not appear to have any direct connection to the mandate. It may reflect adjustments made by employers and insurers due to the high rates of medical inflation during this period, or it may be due to the particular distribution of claims paid during this period.

Also during this period, losses per member per year for mental health services increased by 87.0 percent and the cost of mental health services as a percentage of comprehensive losses per member per year increased from 1.3 percent to 2.2 percent, a relative increase of 0.9 percent. Out of pocket costs for mental health services (the portion of the claim paid by the member) did not increase more than 0.1 percent, whereas total costs (the insurer's portion and member's portion combined) increased by 0.8 percent (see Table 10).

Overall, the data suggests that the cost of mental health services as a percentage of comprehensive losses per member per year increased by 0.9 percent from 1999 to 2002. This is well within the Legislative Fiscal Analyst's previous estimate that the financial impact of the catastrophic mental health statute would be between a 2.0 percent savings and a 7.0 percent increase (see "Fiscal Note for H.B. 35" in the Appendix). It is also consistent with previous cost estimates of mental health statutes (see Review of Previous Cost Estimates).

Source of cost increase. The source of this cost increase appears to be due to a combination of two factors. First, there appears to be a shift from inpatient to outpatient services during 1999 to 2002. For example, the number of inpatient days declined by more than 50 percent, while the number of outpatient visits increased by approximately 80 percent (see Table 11).

Table 11. Breakout of Mental Health Services By Service Type from 1999 to 2002

	1999	2000	2001	2002	Percent Change
Inpatient Services					
Days Per 1000	38.04	37.81	19.52	17.26	-54.6%
Losses PMPY (Paid By Insurer)	$6.18	$5.91	$9.00	$8.39	35.7%
Out Of Pocket Cost PMPY (Paid By Member)	$2.04	$2.05	$1.83	$1.80	-11.5%
Total Cost PMPY (Losses plus Out Of Pocket)	$8.22	$7.96	$10.83	$10.19	24.0%
Percent of Total Cost PMPY Covered By Insurance	75%	74%	83%	82%	7%
Outpatient Services					
Visits Per 1000	101.91	108.00	144.06	183.55	80.1%
Losses PMPY (Paid By Insurer)	$8.89	$10.12	$16.19	$16.56	86.2%
Out Of Pocket Cost PMPY (Paid By Member)	$4.33	$5.16	$7.07	$7.18	65.7%
Total Cost PMPY (Losses plus Out Of Pocket)	$13.23	$15.28	$23.25	$23.74	79.5%
Percent of Total Cost PMPY Covered By Insurance	67%	66%	70%	70%	3%
Mental Health Services Under Capitation	-	$2.05	$2.49	$3.25	58.6%
All Mental Health Services					
Losses PMPY (Paid By Insurer)	$15.08	$18.08	$27.67	$28.20	87.0%
Out Of Pocket Cost PMPY (Paid By Member)	$6.37	$7.21	$8.90	$8.98	41.0%
Total Cost PMPY (Losses plus Out Of Pocket)	$21.45	$25.29	$36.57	$37.18	73.4%
Percent of Total Cost PMPY Covered By Insurance	70%	72%	76%	76%	6%

Data Source: Utah Catastrophic Mental Health Survey
Note: All data is adjusted for medical inflation to 1999 dollars using the Medical Cost Price Index. PMPY means per member per year.

Second, health insurers paid a larger portion of the cost of mental health services. This is consistent with the higher service limits required by the mental health statute. For example, although the number of inpatient days declined during this period, the percentage of total costs per member per year covered by health insurance increased by 7 percent for inpatient services and by 3 percent for outpatient services (an average of 6 percent more overall). So by 2002, health insurers were covering, on average, 76 percent of the costs of mental health services compared to an average of 82 percent of all health services (see Table 10 and 11). Overall, more than 65 percent of the cost increase for commercial health insurers was due to changes in outpatient services, nearly 25 percent was due to changes in inpatient services, and more than 10 percent was due to changes in mental health services under capitation arrangements.

Pharmacy Costs. There are five major classes of psychotropic drugs used for the treatment of mental illness: anti-anxiety, anti-depressants, anti-psychotics/anti-maniacs, sedatives/hypnotics, and central nervous system stimulants. Most health insurers cover psychotropic drugs under their major medical pharmacy benefit and cover these drugs like any other drug (subject to deductibles and co-insurance). As noted previously, two-thirds of all psychotropic drugs are prescribed by physicians in the general medical sector, whereas only one-third are prescribed by psychiatrists in the specialty mental health sector (Pincus, Tanielian, Marcus, Olfson, Thompson, & Magno Zito, 1998; U.S. Department of Health and Human Services, 1999).

Nationally, psychotropic drugs accounted for about 9 percent of mental health costs in 1996 (see Table 4). The Insurance Department's survey design asked health insurers to try to isolate the drug prescriptions written by mental health providers (primarily psychiatrists), however, most companies could not track drugs using this method, as most insurers could not link the provider type with drug claims.

Nevertheless, if the national estimate is applied to the sample data, psychotropic drugs account for approximately 0.6 percent of comprehensive claim costs, with approximately one-third (or 0.2 percent) of that being prescribed in the specialty mental health sector. This suggests that if pharmacy costs were included, the estimated cost of mental services would increase from 2.2 percent to 2.4 percent for 2002. Although the Utah Insurance Department was not able to create a more precise estimate with the data currently available, psychotropic drugs appear to be a relatively small cost component of mental health services.

Review of Previous Cost Estimates

There have been a large number of studies attempting to measure the cost of mental health benefits and the effects of mental health parity legislation. Making comparisons between these studies is sometimes difficult because of differences in how mental health parity is defined, the prevalence of mental illness in the population being studied, the degree of managed care being used, as well as the actuarial assumptions used for the cost and utilization of mental health services (Workshop on Estimating the Costs of Parity, 2001). Because of this, even valid, well-controlled studies may not be comparable to each other or applicable to other groups. This is further complicated by the difficulties associated with evaluating mental health parity (Otten, 1998). However, all of these studies share a common theme, specifically, that all health

insurance benefits (including mental health services) have an economic cost (Hay Group, 1999; Jensen & Morrisey, 1999; GAO, 2003). The question is who pays and how much they pay.

Most of these studies involve cost estimates that are lower than the national expenditure data cited previously. This is likely to due to the changes in managed care since those estimates were created as well as differences in methodology. For example, recent trends suggest that the cost of mental health services as a percentage of total health care costs has declined over the last few years (see Hay Group, 1999).

Review of national cost estimates. During the legislative debate prior to the passage of the federal Mental Health Parity Act, cost estimates for full parity legislation ranged from 2.5 percent to approximately 8-11 percent (Hennessey & Goldman, 2001; Otten, 1998; Sing, Hill, Smolkin, & Heiser, 1998; Frank, Koyanagi, & McGuire, 1997). Concerns about the cost of full parity contributed to the development of the Domenici-Wellstone amendment, a more limited form of mental health parity, which became the federal Mental Health Parity Act of 1996. According to Congressional Budget Office estimates, the version of parity actually implemented cost about 0.4 percent (Otten, 1998; Sing, Hill, Smolkin, Heiser, 1998).

After the federal Mental Health Parity Act was passed, interest in the cost of full mental health parity continued and advances in statistical and actuarial models lead to a new set of revised cost estimates for full mental health parity. Most of these studies were based on the Hay/Higgins Group Mental Health Benefit Value Comparison (MHBVC) Model. The MHBVC was developed by the Hay Group for the National Institute of Mental Health (NIHM) to provide estimates of the costs of mental health parity. This model is based on a "common cost" method rather than actual costs (National Institutes of Mental Health, 2000).

Estimates based on this model range from 4.0 percent to 1.4 percent, including the original 1996 Congressional Budget Office (CBO) estimate of a 4.0 percent increase (prior to the passage of the federal Mental Health Parity Act), the 1998 Substance Abuse and Mental Health Services Administration (SAMHSA) estimate of 3.6 percent, and the 1998 estimates by the National Advisory Mental Health Council (NAMHC) of less than 1.0 to 4.0 percent. The NAMHC estimate was later revised to 1.4 percent. Each of these studies use similar actuarial methods, but are based on different assumptions about utilization and how much managed care will reduce costs (National Institutes of Mental Health, 2000).

Although the Hay's Group model is based on commonly accepted actuarial methods, it has been criticized by some economists for using actuarial assumptions that were based on utilization patterns from the 1970's and 1980's. According to Roland Sturm (Sturm, 2001), these models may not reflect the current mental health treatment systems in the private sector, including the recent increase in the use of managed care. This view is supported by a number of recent studies suggesting that the use of managed care may be one of the most significant factors in how much mental health parity may actually cost (e.g., Goldman, McCulloch, & Sturm, 1998; Sing, Hill, Smolkin, & Heiser, 1998; Sturm, Goldman, & McCulloch, 1998; Sturm, 1997). There is also evidence that mental health parity and managed care are self-reinforcing, that is, as parity legislation has increased so has managed care and vice versa (Gitterman, Sturm, & Scheffler, 2001).

Review of state cost estimates. As shown in Table 1, most states currently have some type of mental health parity statute in force. Some states have produced cost estimates of mental health parity for commercial health insurers. Given the wide variation of what "parity" means among state statutes, cost estimates of state mental health parity laws are not always directly comparable. However, among the cost estimates reviewed here, most fall within the 1 to 4 percent range found in national cost estimates.

Consider the following examples. In Oregon, an independent review of health insurance mandates estimated that gross claim costs for mental health services under a limited mental health parity statute was approximately 3.2 percent (Hand & Choate, 1991). In Wisconsin, a study conducted by the Wisconsin Insurance Commissioner of five major health insurance mandates found that gross claim costs for mental health services under a limited mental health parity statute averaged about 3.2 percent for commercial health plans and 3.1 percent for self-funded plans administered by commercial health insurers (Office of the Commissioner of Insurance, 2002).

In Vermont, the cost of implementing full mental health parity was estimated to be less than 1 percent and gross claim costs for mental health services after parity accounted for approximately 2.5 percent of all health claims (Rosenbach, Lake, Young, Conroy, Quinn, Ingels, Cox, Peterson, & Crozier, 2003). In Virginia, an evaluation of all health insurance mandates estimated that the gross claims costs for mental health services under two limited mental health parity statutes was 3.96 percent (Commonwealth of Virginia, 2003).

Maine implemented full mental health parity in 1996. Based on estimates of gross claim costs for mental health services, costs increased less than 1 percent and gross claim costs remained less than 4.5 percent during 1997 and 1998 (Bachman, 2000).

An actuarial study conducted by Milliman & Robertson for the state of Texas, estimated the cost of various health insurance mandates. In this study, the cost of providing a mandated benefit for serious mental illness was estimated to be 2.0 percent of premium (Albee, Blount, Lee, Litow, & Sturm, 2000). Other reviews of mental health parity at the state level, including Maryland, Rhode Island, and Minnesota have concluded that implementing parity increased costs about 1.0 percent or less (Bachman, 2000).

Although a comprehensive review of all of the state cost estimates for mental health parity is beyond the scope of this report, these studies suggest that many states with mental health parity statutes report gross claim costs of 4.0 percent or less and the cost of implementing parity at the state level is consistent with national cost estimates. Yet, many of these state estimates are limited in how they can be directly compared to Utah's mental health parity legislation. This is because most states with mental health parity have more comprehensive parity statues than Utah (see Table 1) and many of the most important cost factors can vary considerably among states. Furthermore, because much of the available research has focused on full mental health parity, reviews of states with more limited parity laws similar to Utah are less common and less publicized.

However, among the few studies available is Bachman's actuarial study of various parity options in Utah (Bachman, 1996). Prior to the passage of Utah's mental health parity statute, Bachman provided an actuarial model of mental health parity in Utah under four parity options: partial parity, parity for serious mental illness (SMI), full parity, and comprehensive parity. Utah's current mental health parity statute would fall somewhere between partial parity and parity for serious mental illness (SMI). As shown in Table 12, partial parity was estimated to increase costs by approximately 0.7 percent, whereas parity for serious mental illness was estimated to increase costs by approximately 1.9 percent (see Table 12). The Utah Insurance Department's cost estimate of 2.2 percent gross claims costs and a 0.9 percent cost increase appears to be consistent with Bachman's analysis as well as other state and national cost estimates.

Table 12. Summary of Bachman's Actuary Model Results

	Percentage Increase in Base Medical Plan for Change to Type of Parity			
	Partial	**SMI**	**Full**	**Comprehensive**
Composite Market Analysis	0.7%	1.9%	2.4%	2.8%
Composite PMPM	$0.78	$2.13	$2.69	$3.14

Data Source: Adapted from Bachman (1996).

Estimated Benefits

Documenting and presenting the research literature on the benefits of mental health treatment is a complicated undertaking. Mental illness is not a single disease or even a single set of diseases. Thus, providing a complete overview of the relative effectiveness of mental health treatment would take more space than is practical in this report and is really beyond the scope of this evaluation. However, the Surgeon General has published a comprehensive overview of mental health in the United States and includes a review of the effectiveness of many mental health treatments (see U.S. Health and Human Services, 1999). The Surgeon General report concludes that, in general, appropriate mental health treatment reduces health care costs, improves productivity and quality of life, and is generally effective in reducing the symptoms of mental illness. However, like treatments for physical health conditions, these benefits typically come when quality care is received (i.e., the correct diagnosis is made combined with appropriate treatment). Other federal reviews also support this conclusion (National Institutes of Mental Health, 2000; New Freedom Commission on Mental Health, 2004). Although the available data did not permit the Utah Insurance Department to evaluate these factors directly, the available information suggests at least three trends that may be beneficial to commercially insured residents with mental illness.

Increase in mental health coverage. The data suggests that few employers reduced or eliminated coverage and some increased coverage. The percentage of commercially insured members with health insurance coverage for the treatment of mental illness increased from 80 percent in 1999 to 93 percent in 2002. This benefit primarily affects about 13 percent of the group comprehensive health insurance market. There may also have been a general increase in the average minimum level of coverage for commercially insured residents with a group health insurance policy, which affects approximately 29 percent of Utah residents.

Shift from inpatient to outpatient services. The number of inpatient days declined by 50 percent, while outpatient services increased by more than 80 percent. The decline in inpatient services may lead to cost savings in some cases as inpatient services generally cost more than outpatient services. This benefit primarily affects those who use mental health services under a commercial group health insurance policy, which is approximately 1.0 to 1.7 percent of Utah residents.

Financial benefits. Commercial health insurers paid a greater percentage of the costs of mental health services in 2002 than in 1999. For example, health insurers paid approximately 70 percent of the cost of mental health services in 1999. By 2002, health insurers were paying about 76 percent of the costs, a 6 percent increase. This increase could be considered to be near full parity levels, given the fact that during 2002 health insurers were paying 82 percent of total claim costs for all types of health services. While this increase likely provides a financial benefit to consumers, it also means that health insurers also experienced an increase in the underlying costs of health insurance. This benefit primarily affects those who use mental health services under a group comprehensive health insurance policy, which is approximately 1.0 to 1.7 percent of Utah residents.

Summary

The purpose of this report is to comply with the statutory requirements of Utah Code Annotated (U.C.A.) § 31A-22-625(6)(b), which requires the Utah Insurance Commissioner to report to the Health and Human Services Interim Committee the percentage of contracts and policies with mental health coverage as permitted under U.C.A. § 31A-22-625. The report also includes the results of the Utah Insurance Department's research study, which estimates the impact of the catastrophic mental health statute on the commercial health insurance market during 1999 to 2002. The study is based on information obtained from commercial health insurers, the Utah Department of Health, and the available research literature on mental health and mental health parity statutes. Using four years of data from approximately 90 percent of the commercial health insurance market (ranging from approximately 78 percent of the market in 1999 to 98 percent of the market in 2002), the Utah Insurance Department estimated the impact of the catastrophic mental health statute on commercial health insurance coverage, the commercially insured population with mental illness, and comprehensive claim costs in the commercial group health insurance market.

Coverage Impact. In 1999, prior to the passage of the catastrophic mental health statute, nearly 80 percent of commercially insured members had some type of mental health coverage. This percentage appears to have increased after the catastrophic mental health statute was in place. For example, by 2002, nearly 93 percent of commercially insured members had some type of mental health coverage, a 13 percent increase from 1999 to 2002.

This increase in coverage occurred in both the large and small group markets, with a slightly greater impact in the small group market. Generally, the data suggest that few employers terminated coverage during this period and some chose to increase coverage for the treatment of mental illness. Furthermore, mental health coverage also appears to have become more standardized during this period. For example, by 2002, most small group plans reported

fifty/fifty coverage, whereas most large group plans reported catastrophic coverage. Few health insurers reported coverage that exceeded the minimum requirements of the catastrophic mental health statute.

Population Impact. The catastrophic mental health statute applies only to employer group plans in the commercial health insurance market. This market provides coverage for approximately 29 percent of Utah residents. Based on national prevalence estimates of mental illness, between 1.0 and 1.7 percent of Utah residents and their families are directly affected by the statute.

Financial Impact. Financial impact was measured using data from 1999 to 2002. All data was adjusted to 1999 dollars using the Medical Care Price Index and weighted by member years. During this four-year period, average comprehensive losses per member per year increased by 11.8 percent, whereas mental health losses per member per year increased by approximately 87.0 percent.

To put this cost increase in perspective, the cost of mental health services as a percentage of comprehensive losses per member per year increased from 1.3 percent in 1999 to 2.2 percent in 2002, a relative increase of 0.9 percent. Thus, mental health services, as measured in this study, did not exceed 2.2 percent of comprehensive losses per member per year during the four years data was available and does not appear to have increased comprehensive claim costs more than 1.0 percent. The Utah Insurance Department's cost estimate is consistent with the Legislative Fiscal Analyst's previous estimate that the premium impact of the catastrophic mental health statute would range between a 2.0 percent savings and a 7.0 percent increase (see Appendix). It is also consistent with other national and state cost estimates of mental health parity legislation.

Estimated Benefits. Reviews of mental health treatment, such as the Surgeon General's report on mental health, suggest that mental health treatment can be effective in reducing the symptoms of mental illness, which in turn may reduce health care costs, increase productivity, and improve the quality of life for those with mental illness and their families. Although the available data did not permit the Utah Insurance Department to test these factors directly, the data did suggest three trends that may be beneficial to commercially insured members with mental illness. First, there was a moderate increase in the number of commercially insured members with insurance coverage for the treatment of mental illness. Second, there was a significant decline in the number of inpatient days per member per year and an increase in the number of outpatient visits per member per year, which suggests a shift from inpatient to outpatient services. Third, commercial health insurers covered a larger percentage of the cost of mental health services in 2002 than in 1999. While this provided a financial benefit to members who utilized mental health services, it also increased the average cost per claim for mental health services among commercial health insurers.

References

Albee, S. K., Blount, E., Lee, T. D., Litow, M., & Sturm, M. (2000). Cost Impact Study of Mandated Benefits in Texas. Milliman & Robertson, Inc.

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., Text Revision). Washington, D.C.: Author.

Bachman, R. E. (1996). An Actuarial Analysis for Parity for Serious Mental Illness and Other Options for Improved Mental Health Coverage in Utah. Atlanta, GA: Cooper & Lybrand, L.L.P.

Bachman, R. E. (2000). Mental Health Parity: "Just the Facts" -- Actual Data and Experience Reports. (Prepared for the American Psychological Association, 2000 State Leadership Conference). Atlanta, GA: PriceWaterHouseCoopers.

Children With Serious Emotional Disturbance, Federal Register (Vol. 63, No. 137), 38661-38665 (1998).

Commonwealth of Virginia. (2003). The Financial Impact of Mandated Health Insurance Benefits and Providers Pursuant to Section 38.2-3419.1 of the Code of Virginia: 2001 Reporting Period (Annual Report of the State Corporation Commission, House Document No. 8). Richmond, VA: Author.

Frank, R. G., Koyanagi, C. & McGuire, T. G. (1997). The politics and economics of mental health 'parity' laws. Health Affairs, 16(4), 108-119.

GAO. (2003). Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses (GAO-03-1133). Washington, D.C.: United States General Accounting Office.

Geertsen, D. C., Colton, C. W., Justice, D. H., & Taylor, M. (2003). Public Mental Health: Services, Client Statistics, Outcomes, and Satisfaction Data for Use in Continuous Quality Improvement (Fiscal Years 2001 and 2002). Salt Lake City, UT: Utah Department of Human Services.

Gitterman, D. P., Sturm, R., & Scheffler, R. M. (2001). Toward full mental health parity and beyond: Managed behavioral health care has made full parity affordable-and therefore thinkable. Health Affairs, 20(4), 68-76.

Goldman, W., McCulloch, J., & Sturm, R. (1998). Costs and utilization of mental health services before and after managed care. Health Affairs, 17(2), 40-52.

Hand, M. L., & Choate, G. M. (1991). The Impact of State-Mandated Health Care Benefits in Oregon: A Public Policy Research Report. Salem, OR: Associated Oregon Industries Foundation.

Hay Group. (1999). Health Care Plan Design and Cost Trends – 1988 through 1998 (prepared for the National Association of Psychiatric Health Systems and Association of Behavioral Group Practices). Arlington, VA: Author.

Hennessy, K. D., & Goldman, H. H. (2001). Full parity: Steps toward treatment equity for mental and addictive disorders. Health Affairs, 20(4), 58-67.

Jensen, G. A., & Morrisey, M. A. (1999). Mandated benefit laws and employer-sponsored health insurance. Washington, D.C.: Health Insurance Association of America.

Kaiser/HRET. (2002). Employer Health Benefits: 2002 Annual Survey. Menlo Park, CA: Kaiser Family Foundation/Health Research and Educational Trust.

Mental Health Parity Act of 1996, 42 United States Code Service (U.S.C.S.) § 300gg-5 (1999).

Mental Health Parity Reauthorization Act of 2003, S. 1929, 108th Congress, 1st Session. (2003).

Murray, C. J. L., & Lopez, A. D. (Eds.). (1996). The global burden of disease: A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020. Cambridge, MA: Harvard School of Public Health.

National Advisory Mental Health Council. (1993). Health care reform for Americans with severe mental illnesses: Report of the National Advisory Mental Health Council. American Journal of Psychiatry, 150, 1447–1465.

National Conference of State Legislatures. (2004). State Laws Mandating or Regulating Mental Health Benefits [Online]. Available: http://www.ncls.org/programs/health/Mentalben.htm

National Institutes of Mental Health. (2000). Insurance Parity For Mental Health: Cost, Access, and Quality (Final Report to Congress by the National Advisory Mental Health Council) (NIH Publication No. 00-4787). Washington, D.C.: Department of Health and Human Services, National Institutes of Health.

New Freedom Commission on Mental Health. (2004). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Author.

Office of the Commissioner of Insurance. (2002). Study of Costs of Certain Mandated Benefits in Insurance Policies 2001. Madision, WI: Author.

Otten, A. L. (1998). Mental Health Parity: What Can It Accomplish in a Market Dominated by Managed Care? New York, NY: Milbank Memorial Fund.

Pincus, H. A., Tanielian, T. L., Marcus, S. C., Olfson, M., Zarin, D. A., Thompson, J., & Magno Zito, J. M. (1998). Prescribing trends in psychotropic medications: Primary care, psychiatry, and other medical specialties. Journal of the American Medical Association, 279, 526–531.

Regier, D. A., Narrow, W., Rae, D. S., Manderscheid, R. W., Locke, B. Z., & Goodwin, F. K. (1993). The de facto US mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. Archives of General Psychiatry, 50, 85–94.

Rickert, A., & Ro, M. (2003). Mental Health Parity: State of the States (April 2003 Update). Battle Creek, MI: W. K. Kellogg Foundation.

Rosenbach, M., Lake, T., Young, C., Conroy, W., Quinn, B., Ingels, J., Cox, B., Peterson, A., & Crozier, L. (2003). Effects of the Vermont Mental Health and Substance Abuse Parity Law. DHHS Pub. No. (SMA) 03-3822. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Sing, M., Hill. S., Smolkin S., & Heiser, N. (1998). The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits (DHHS Publication 98-3205). Rockville, MD: Center for Mental Health Services.

Sturm, R. (1997). How expensive is unlimited mental health care coverage under managed care? Journal of the American Medical Association, 278(18), 1533-1537.

Sturm, R. (2001). The Costs of Covering Mental Health and Substance Abuse Care at the Same Level as Medical Care in Private Insurance Plans (Presented to the Health Insurance Committee, National Conference of Insurance Legislators). Santa Monica, CA: RAND.

Sturm, R., Goldman, W., & McCulloch, J. (1998). Mental health and substance abuse parity: A case study of Ohio's State Employee Program. The Journal of Mental Health Policy and Economics, 1, 129-134.

U. S. Department of Health and Human Services. (1999). Mental Health: A Report to the Surgeon General. Rockville, M.D.: U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Utah Insurance Department. (2003). 2002 Health Insurance Market Report. Salt Lake City, UT: Author.

Utah State Division of Substance Abuse and Mental Health. (2003). Mental Health Community Services FY2002 Fact Sheet. Salt Lake City, UT: Utah Department of Human Services.

Workshop on Estimating the Costs of Parity. (2001). Estimating the Costs of Mental Health Parity: Methods and Evidence. Washington, D.C.: The Robert Wood Johnson Foundation.

World Health Organization. (2001). The World Health Report 2001 - Mental Health: New Understanding, New Hope. Geneva: World Health Organization.

Appendix

U. C. A. § 31A-22-625

31A-22-625. **Catastrophic coverage of mental health conditions.**
(Effective only until 7/1/2011.)

(1) As used in this section:

(a) (i) "Catastrophic mental health coverage" means coverage in a health insurance policy or health maintenance organization contract that does not impose any lifetime limit, annual payment limit, episodic limit, inpatient or outpatient service limit, or maximum out-of-pocket limit that places a greater financial burden on an insured for the evaluation and treatment of a mental health condition than for the evaluation and treatment of a physical health condition.

(ii) "Catastrophic mental health coverage" may include a restriction on cost sharing factors, such as deductibles, copayments, or coinsurance, prior to reaching any maximum out-of-pocket limit.

(iii) "Catastrophic mental health coverage" may include one maximum out-of-pocket limit for physical health conditions and another maximum out-of-pocket limit for mental health conditions, provided that, if separate out-of-pocket limits are established, the out-of-pocket limit for mental health conditions may not exceed the out-of-pocket limit for physical health conditions.

(b) (i) "50/50 mental health coverage" means coverage in a health insurance policy or health maintenance organization contract that pays for at least 50% of covered services for the diagnosis and treatment of mental health conditions.

(ii) "50/50 mental health coverage" may include a restriction on episodic limits, inpatient or outpatient service limits, or maximum out-of-pocket limits.

(c) "Large employer" is as defined in Section 31A-1-301.

(d) (i) "Mental health condition" means any condition or disorder involving mental illness that falls under any of the diagnostic categories listed in the Diagnostic and Statistical Manual, as periodically revised.

(ii) "Mental health condition" does not include the following when diagnosed as the primary or substantial reason or need for treatment:

(A) marital or family problem;

(B) social, occupational, religious, or other social maladjustment;

(C) conduct disorder;

(D) chronic adjustment disorder;

(E) psychosexual disorder;

(F) chronic organic brain syndrome;

(G) personality disorder;

(H) specific developmental disorder or learning disability; or

(I) mental retardation.

(e) "Small employer" is as defined in Section 31A-1-301.

(2) (a) At the time of purchase and renewal, an insurer shall offer to each small employer that it insures or seeks to insure a choice between catastrophic mental health coverage and 50/50 mental health coverage.

(b) In addition to Subsection (2)(a), an insurer may offer to provide:

(i) catastrophic mental health coverage, 50/50 mental health coverage, or both at levels that exceed the minimum requirements of this section; or

(ii) coverage that excludes benefits for mental health conditions.

(c) A small employer may, at its option, choose either catastrophic mental health coverage, 50/50 mental health coverage, or coverage offered under Subsection (2)(b), regardless of the employer's previous coverage for mental health conditions.

(d) An insurer is exempt from the 30% index rating restriction in Subsection 31A-30-106(1)(b) and, for the first year only that catastrophic mental health coverage is chosen, the 15% annual adjustment restriction in Subsection 31A-30-106(1)(c)(ii), for any small employer with 20 or less enrolled employees who chooses coverage that meets or exceeds catastrophic mental health coverage.

(3) (a) At the time of purchase and renewal, an insurer shall offer catastrophic mental health coverage to each large employer that it insures or seeks to insure.

(b) In addition to Subsection (3)(a), an insurer may offer to provide catastrophic mental health coverage at levels that exceed the minimum requirements of this section.

(c) A large employer may, at its option, choose either catastrophic mental health coverage, coverage that excludes benefits for mental health conditions, or coverage offered under Subsection (3)(b).

(4) (a) An insurer may provide catastrophic mental health coverage through a managed care organization or system in a manner consistent with the provisions in Chapter 8, Health Maintenance Organizations and Limited Health Plans, regardless of whether the policy or contract uses a managed care organization or system for the treatment of physical health conditions.

(b) (i) Notwithstanding any other provision of this title, an insurer may:

(A) establish a closed panel of providers for catastrophic mental health coverage; and

(B) refuse to provide any benefit to be paid for services rendered by a nonpanel provider unless:

(I) the insured is referred to a nonpanel provider with the prior authorization of the insurer; and

(II) the nonpanel provider agrees to follow the insurer's protocols and treatment guidelines.

(ii) If an insured receives services from a nonpanel provider in the manner permitted by Subsection (4)(b)(i)(B), the insurer shall reimburse the insured for not less than 75% of the average amount paid by the insurer for comparable services of panel providers under a noncapitated arrangement who are members of the same class of health care providers.

(iii) Nothing in this Subsection (4)(b) may be construed as requiring an insurer to authorize a referral to a nonpanel provider.

(c) To be eligible for catastrophic mental health coverage, a diagnosis or treatment of a mental health condition must be rendered:

(i) by a mental health therapist as defined in Section 58-60-102; or

(ii) in a health care facility licensed or otherwise authorized to provide mental health services pursuant to Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act, or Title 62A, Chapter 2, Licensure of Programs and Facilities, that provides a program for the treatment of a mental health condition pursuant to a written plan.

(5) The commissioner may disapprove any policy or contract that provides mental health coverage in a manner that is inconsistent with the provisions of this section.

(6) The commissioner shall:

(a) adopt rules as necessary to ensure compliance with this section; and

(b) provide general figures on the percentage of contracts and policies that include no mental health coverage, 50/50 mental health coverage, catastrophic mental health coverage, and coverage that exceeds the minimum requirements of this section.

(7) The Health and Human Services Interim Committee shall review:

(a) the impact of this section on insurers, employers, providers, and consumers of mental health services before January 1, 2004; and

(b) make a recommendation as to whether the provisions of this section should be modified and whether the cost-sharing requirements for mental health conditions should be the same as for physical health conditions.

(8) (a) An insurer shall offer catastrophic mental health coverage as part of a health maintenance organization contract that is governed by Chapter 8, Health Maintenance Organizations and Limited Health Plans, that is in effect on or after January 1, 2001.

(b) An insurer shall offer catastrophic mental health coverage as a part of a health insurance policy that is not governed by Chapter 8, Health Maintenance Organizations and Limited Health Plans, that is in effect on or after July 1, 2001.

(c) This section does not apply to the purchase or renewal of an individual insurance policy or contract.

(d) Notwithstanding Subsection (8)(c), nothing in this section may be construed as discouraging or otherwise preventing insurers from continuing to provide mental health coverage in connection with an individual policy or contract.

(9) This section shall be repealed in accordance with Section 63-55-231.
(Repealed by the provisions of Section 63-55-231, eff. 7/1/2011.)

Fiscal Note for H.B. 35

The fiscal impact of this bill has several facets. First, groups are not required to purchase mental health coverage, though it must be offered. This could keep some groups insurance rates lower. Second, mental health insurance coverage could significantly increase in price, if only select policies offer this type of coverage. Third, HMO organizations may need to adjust plan rates immediately to comply with the effective date of the bill; and, there will be additional costs and revenue to the Insurance Department to review and process rate changes. There may be no fiscal impact to groups or individuals that decide not to accept mental health coverage. If the coverage is accepted, it is estimated that this bill could affect health insurance premiums ranging between a savings of 2.0 percent and an increase of 7.0 percent depending on 1) the current level of general health benefits offered; 2) the current level of mental health coverage provided; 3) changes in future health care usage; and 4) the type of health care system used by the insurance plan. Employers have options to offer policies but are not required to include mental health in all of them. The impact on State and local government, public school districts, State higher education and some private businesses will begin in FY 2002. Those organizations that use HMO's including some local governments and school districts, and many small businesses may experience a fiscal impact in FY 2001 depending on the options selected. State premiums will not be affected in the first year. The State Public Employees Health Program intends to offer two benefit plan options with mental health parity provisions. Changes in usage rate may affect future costs. The State's Public Employee Health Program is not required to adopt the changes to the State Insurance Code, though it has traditionally done so. Higher and public education premiums could rise. Some of these organizations may be affected in FY 2001. A 1.0 percent FY 2002 estimate for institutions of higher education that are not exempt is estimated to be approximately $450,000. Costs for public education of 1 percent equal $850,000. This may be required for districts that are not exempt. Groups that use HMO's may have additional expenses in FY 2001. There will be no fiscal impact to companies and organizations, which are exempt from the provisions of this bill due to the Employee Retirement Securities Act of 1974 (ERISA). A one-time appropriation of $4,000 from the General Fund to the Insurance Department is necessary to process forms and implement the provisions of the bill. New rate filings could generate approximately $16,000 to the General Fund. Enactment of this bill could generate Medicaid savings because of the increased private insurance coverage, however, this could not be quantified. There may be an increase in revenue to State mental health facilities. It is estimated this could be positive revenue of approximately $350,000 per year and would be used to provide care for additional patients.

General Fund	$4,000	$0	$16,000	$0
General Fund			$0	$0
Dedicated Credits Revenue	$0	$350,000	$0	$350,000
TOTAL	$4,000	0	$16,000	$350,000

Office of the Legislative Fiscal Analyst